		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040303

Facility Name: PRAIRIE VIEW CARE CENTER-LEWISTOWN

Address: 175 E. SYCAMORE (Number) LEWISTOWN (City) 61542 (Zip Code)

County: FULTON

Telephone Number: (847)674-4700 **Fax #** (847)674-4733

IDPA ID Number: 36-1304214

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,610	1,610	8
9	SNF/PED					9
10	ICF	14,258	4,484	187	18,929	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,258	4,484	1,797	20,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.84%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,610

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTC # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	100,744	6,371	7,033	114,148		114,148		114,148			1
2	Food Purchase		101,774		101,774		101,774	(3,934)	97,840			2
3	Housekeeping	78,966	17,680		96,646		96,646	220	96,866			3
4	Laundry	32,690	16,109	155	48,954		48,954		48,954			4
5	Heat and Other Utilities			47,517	47,517		47,517	356	47,873			5
6	Maintenance	19,677	14,272	9,735	43,684		43,684	365	44,049			6
7	Other (specify):*			3,954	3,954		3,954		3,954			7
8	**TOTAL General Services**	232,077	156,206	68,394	456,677		456,677	(2,993)	453,684			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	780,914	83,543	31,539	895,996		895,996	9,446	905,442			10
10a	Therapy		409	573	982		982		982			10a
11	Activities	40,073		709	40,782		40,782		40,782			11
12	Social Services	37,891		3,206	41,097		41,097		41,097			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	858,878	83,952	41,527	984,357		984,357	9,446	993,803			16
	C. General Administration											
17	Administrative	4,305		17,800	22,105		22,105	6,890	28,995			17
18	Directors Fees											18
19	Professional Services			53,858	53,858		53,858	5,174	59,032			19
20	Dues, Fees, Subscriptions & Promotions			22,093	22,093		22,093	(10,173)	11,920			20
21	Clerical & General Office Expenses	60,861	13,115	84,604	158,580		158,580	(18,051)	140,529			21
22	Employee Benefits & Payroll Taxes			167,202	167,202		167,202	10,413	177,615			22
23	Inservice Training & Education											23
24	Travel and Seminar			289	289		289	4,346	4,635			24
25	Other Admin. Staff Transportation			5,130	5,130		5,130	4,456	9,586			25
26	Insurance-Prop.Liab.Malpractice			45,959	45,959		45,959	2,463	48,422			26
27	Other (specify):*											27
28	**TOTAL General Administration**	65,166	13,115	396,935	475,216		475,216	5,518	480,734			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,156,121	253,273	506,856	1,916,250		1,916,250	11,971	1,928,221			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN #0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			18,805	18,805		18,805	100,679	119,484			30
31	Amortization of Pre-Op. & Org.							2,284	2,284			31
32	Interest			109,317	109,317		109,317	317,361	426,678			32
33	Real Estate Taxes			21,422	21,422		21,422		21,422			33
34	Rent-Facility & Grounds			418,438	418,438		418,438	(415,404)	3,034			34
35	Rent-Equipment & Vehicles			1,827	1,827		1,827		1,827			35
36	Other (specify):*											36
37	**TOTAL Ownership**			569,809	569,809		569,809	4,920	574,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			110,606	110,606		110,606		110,606			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			164,809	164,809		164,809		164,809			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,156,121	253,273	1,241,474	2,650,868		2,650,868	16,891	2,667,759			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(34,460)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(3,555)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(379)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(254)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,676)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(724)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,048)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	65,939	SCHED	34
35	Other- Attach Schedule		ATTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 65,939		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 16,891		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PRAIRIE VIEW CARE CENTER-LEWISTOWN

ID# 0040303

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,934)	0	0	0	0	0	0	0	0	0	0	(3,934)	2
3	Housekeeping	0	0	220	0	0	0	0	0	0	0	0	220	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	356	0	0	0	0	0	0	0	0	356	5
6	Maintenance	0	0	365	0	0	0	0	0	0	0	0	365	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,934)	0	941	0	0	0	0	0	0	0	0	(2,993)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	9,446	0	0	0	0	0	0	0	0	9,446	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	9,446	0	0	0	0	0	0	0	0	9,446	16
	C. General Administration													
17	Administrative	0	(17,800)	24,690	0	0	0	0	0	0	0	0	6,890	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	5,174	0	0	0	0	0	0	0	0	5,174	19
20	Fees, Subscriptions & Promotions	(10,400)	0	227	0	0	0	0	0	0	0	0	(10,173)	20
21	Clerical & General Office Expenses	(254)	(70,801)	53,004	0	0	0	0	0	0	0	0	(18,051)	21
22	Employee Benefits & Payroll Taxes	0	0	10,413	0	0	0	0	0	0	0	0	10,413	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,346	0	0	0	0	0	0	0	0	4,346	24
25	Other Admin. Staff Transportation	0	0	4,456	0	0	0	0	0	0	0	0	4,456	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,463	0	0	0	0	0	0	0	0	2,463	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,654)	(88,601)	104,773	0	0	0	0	0	0	0	0	5,518	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,588)	(88,601)	115,160	0	0	0	0	0	0	0	0	11,971	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(34,460)	133,558	1,581	0	0	0	0	0	0	0	0	100,679	30
31	Amortization of Pre-Op. & Org.	0	2,284	0	0	0	0	0	0	0	0	0	2,284	31
32	Interest	0	317,321	40	0	0	0	0	0	0	0	0	317,361	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(418,438)	3,034	0	0	0	0	0	0	0	0	(415,404)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(34,460)	34,725	4,655	0	0	0	0	0	0	0	0	4,920	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(49,048)	(53,876)	119,815	0	0	0	0	0	0	0	0	16,891	45

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/
				MANAGEMENT		MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 17,800			$	$ (17,800)	1
2	V	21	BOOKKEEPING FEES	71,040				(71,040)	2
3	V								3
4	V	34	RENT	418,438	PRAIRIEVIEW CARE CENTER OF LEWISTOWN LLC			(418,438)	4
5	V								5
6	V	30	DEPRECIATION		" " " "		133,558	133,558	6
7	V	31	AMORTIZATION		" " " "		2,284	2,284	7
8	V	32	INTEREST		" " " "		317,321	317,321	8
9	V	21	OFFICE EXPENSE		" " " "		239	239	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 507,278			$ 453,402	$ * (53,876)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 220	$ 220	15
16	V	5	ELECTRICITY & GAS		" " "		356	356	16
17	V	6	MAINTENANCE		" " "		365	365	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		9,446	9,446	18
19	V	17	ADMIN SALARIES		" " "		24,690	24,690	19
20	V	19	PROFESSIONAL FEES		" " "		5,174	5,174	20
21	V	20	FEES, SUBSCRIPTIONS		" " "		227	227	21
22	V	21	OFFICE EXPENSE		" " "		53,004	53,004	22
23	V	22	EMPLOYEE BENEFITS		" " "		10,413	10,413	23
24	V	24	TRAVEL/SEMINAR		" " "		4,346	4,346	24
25	V	25	TRANSPORTATION		" " "		4,456	4,456	25
26	V	26	INSURANCE		" " "		2,463	2,463	26
27	V	30	DEPRECIATION		" " "		1,581	1,581	27
28	V	32	INTEREST		" " "		40	40	28
29	V	34	OFFICE RENT		" " "		3,034	3,034	29
30	V	35	EQUIPMENT RENT		" " "		0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 119,815	$ * 119,815	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWIST # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE			SCHEDULE ATTACHED			$ 13,075	17-3	1
2	HOWARD GELLER		ADMINISTRATIVE			SCHEDULE ATTACHED			4,725	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	$ 3,000	$	20,539	$ 220	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839		20,539	356	2
3	6	MAINTENANCE	" " "	279,537	8	4,965		20,539	365	3
4	10	NURSING/MEDICAL RECORDS	" " "	279,537	8	128,566	128,566	20,539	9,446	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	336,038	20,539	24,690	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412		20,539	5,174	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089		20,539	227	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	572,980	20,539	53,004	8
9	22	EMPLOYEE BENEFITS	" " "	279,537	8	141,722		20,539	10,413	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144		20,539	4,346	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651		20,539	4,456	11
12	26	INSURANCE	" " "	279,537	8	33,528		20,539	2,463	12
13	30	DEPRECIATION	" " "	279,537	8	21,518		20,539	1,581	13
14	32	INTEREST	" " "	279,537	8	549		20,539	40	14
15	34	OFFICE RENT	" " "	279,537	8	41,293		20,539	3,034	15
16	35	EQUIPMENT RENT	" " "	279,537	8			20,539	0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,630,698	$ 1,037,584		$ 119,815	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTC # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANK FINANCIAL		X		$7,359.00	4/00	$ 365,314	$ 282,683	9/02	10.5000	$ 24,522	1
2	GERSHON BASSMAN	X			$8,672.00	4/00	913,284	884,757	3/20	9.7500	87,098	2
3	CIB BANK		X		$20,375.00	4/00	2,118,819	2,061,599	3/20	9.7500	205,701	3
4												4
5	SHAREHOLDER/OFFICER	X						1,686,709			90,508	5
	Working Capital											
6	CIB BANK		X	LINE OF CREDIT				373,830		PRIME+	17,756	6
7	AICC		X	INS FINANCING							1,053	7
8	RELATED PARTY	X									40	8
9	TOTAL Facility Related				$36,406.00		$ 3,397,417	$ 5,289,578			$ 426,678	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,397,417	$ 5,289,578			$ 426,678	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	21,863	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	21,428	2
3. Under or (over) accrual (line 2 minus line 1).	$	(435)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	21,857	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	21,422	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	21,939	8
	1997	20,965	9
	1998	20,723	10
	1999	21,434	11
	2000	21,428	12

CURRENT YEAR ACCRUAL BASED ON PRIOR YEAR OF NO SIGNIFICANT CHANGE

PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX YEAR

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRAIRIE VIEW CARE CENTER-LEWISTOWN COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0040303

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-19-27-141-004		$ 21,428.16	$ 21,428.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,428.16	$ 21,428.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 148,500	1
2					2
3	TOTALS			$ 148,500	3

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2000		$ 2,673,000	$ 133,558	27.5	$ 97,200	$ (36,358)	$ 202,414	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AUTO SPRINKLER			1993	17,150	439	39	439		3,531	9
10	CONDENSOR			1993	2,414	62	39	62		524	10
11	EXPANDER			1993	6,354	163	39	163		1,338	11
12	NEW DOOR			1993	620	17	39	17		134	12
13	FIRE ALARM			1994	6,942	178	39	178		1,417	13
14	CIBICLE TRACKS/CURTAINS			1994	8,149	209	39	209		1,629	14
15	ARCHITECH CONSULTING			1994	1,050	27	39	27		201	15
16	TILE			1995	1,113	29	39	29		199	16
17	REPLACE SHINGLES			1997	1,075	27	39	27		128	17
18	MODIFIED BITUMEN RUBBER PLUMPING/TILES			1997	13,173	338	39	338		1,592	18
19	INSTALL METALCAP			1997	2,670	68	39	68		315	19
20	ROOF REPAIR			1998	12,640	324	39	324		1,121	20
21	FLOOR TILE			1998	8,800	226	39	226		706	21
22	BATHROOM & CEILING REMODELING			1999	18,947	486	39	486		1,359	22
23	LANDSCAPING			1999	2,935	196	15	196		490	23
24	BOILER REPAIR			2000	2,159	529	20	108	(421)	837	24
25	NEW ROOF WEST WING			2000	6,000	218	27.5	218		245	25
26	FAUCETS FOR KITCHEN			2001	1,107	39	27.5	20	(19)	39	26
27	KITCHEN SINK			2001	1,671	48	27.5	30	(18)	48	27
28	A/C UNITS			2001	2,115	48	27.5	38	(10)	48	28
29	BUMPER GUARDS			2001	5,460	58	27.5	99	41	58	29
30	WALLPAPER			2001	2,708	387	7	193	(194)	387	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,798,252	$ 137,674		$ 100,695	$ (36,979)	$ 218,760	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 111,000	$ 10,188	$ 11,104	$ 916	10 YRS	$ 59,740	71
72	Current Year Purchases	1,633	302	82	(220)	10 YRS	860	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	18,981	1,581	1,898	317	10 YRS	16,431	74
75	TOTALS	$ 131,614	$ 12,071	$ 13,084	$ 1,013		$ 77,031	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT,NURSGIN,ACTV	1985 DODGE VAN	1996	$ 4,775	$ 275	$ 596	$ 321	8	$ 5,050	76
77				20,436	3,924	5,109	1,185	4	11,588	77
78										78
79										79
80	TOTALS			$ 25,211	$ 4,199	$ 5,705	$ 1,506		$ 16,638	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,103,577	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 153,944	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 119,484	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (34,460)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 312,429	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,827 Description: SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 33,717	$		$ 33,717	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,952			6,952	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			65,546			65,546	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RESP THERAPIST					4,391			4,391	13
14	TOTAL			$		$ 110,606	$		$ 110,606	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	392,696		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,871		6
7	Other Prepaid Expenses	1,157		7
8	Accounts Receivable (owners or related parties)	91,862		8
9	Other(specify): R/E TAX ESCROW	5,844		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 544,430	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	125,251		15
16	Equipment, at Historical Cost	137,843		16
17	Accumulated Depreciation (book methods)	(129,667)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 133,427	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 677,857	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 194,138	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	500		28
29	Short-Term Notes Payable	373,830		29
30	Accrued Salaries Payable	45,836		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,506		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,857		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 639,667	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,686,709		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	1,024,276		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,710,985	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,350,652	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,672,795)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 677,857	$	48

***(See instructions.)**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,258,263)	1
2	Restatements (describe):		2
3	W/O DUE TO/FROM MEDICARE	18,212	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,240,051)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(432,744)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (432,744)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,672,795)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,126,027	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,126,027	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,466	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 74,466	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	3,555	28
28a	PRIOR YEAR ADJS	14,076	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,631	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,218,124	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	456,677	31
32	Health Care	984,357	32
33	General Administration	475,216	33
	B. Capital Expense		
34	Ownership	569,809	34
	C. Ancillary Expense		
35	Special Cost Centers	110,606	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,650,868	40
41	**Income before Income Taxes (line 30 minus line 40)****	(432,744)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (432,744)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,355	1,355	$ 29,531	$ 21.79	1
2	Assistant Director of Nursing	1,960	2,080	34,119	16.40	2
3	Registered Nurses	6,049	6,229	114,630	18.40	3
4	Licensed Practical Nurses	9,644	9,902	137,344	13.87	4
5	Nurse Aides & Orderlies	46,308	47,427	408,338	8.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,175	2,343	21,495	9.17	8
9	Activity Director	1,923	2,020	24,452	12.10	9
10	Activity Assistants	2,033	2,137	15,621	7.31	10
11	Social Service Workers	3,670	4,072	37,891	9.31	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	22,509	10.82	13
14	Head Cook	4,572	4,624	39,228	8.48	14
15	Cook Helpers/Assistants	4,622	4,862	39,007	8.02	15
16	Dishwashers					16
17	Maintenance Workers	1,722	1,821	19,677	10.81	17
18	Housekeepers	10,612	11,244	78,966	7.02	18
19	Laundry	4,715	4,891	32,690	6.68	19
20	Administrator	213	213	4,305	20.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,015	2,084	25,599	12.28	23
24	Clerical	1,643	1,643	12,294	7.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,961	2,025	22,968	11.34	31
32	Other Health C: care plan coord	2,000	2,080	35,457	17.05	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,168	115,132	$ 1,156,121 *	$ 10.04	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,994	1-3	35
36	Medical Director		5,500	9-3	36
37	Medical Records Consultant		14,945	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,325	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		573	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,206	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,543		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TAMMY BONNEY	ADMINISTRATOR	0	$ 4,305
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 4,305

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 17,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 17,800

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK,BOKOR	ACCTG	$ 14,200
PERSONNEL PLANNERS	HR	815
ECONOCARE	ADMIN CONSULT	1,782
WINSTON&STRAWN	LEGAL	1,229
MILLENIUM/PAYMASTER	DATA PROCESSING	4,491
CERTIFIED HEATLH	ADMIN CONSULT	31,341
RELATED PARTY		5,174
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 59,032

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,583
Unemployment Compensation Insurance	15,242
FICA Taxes	88,443
Employee Health Insurance	34,962
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other	(28)
RELATED PARTY	10,413
TOTAL (agree to Schedule V, line 22, col.8)	$ 177,615

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,144
Health Care Worker Background Check (Indicate # of checks performed)	
ADV & PROMO-MKTG	9,676
DUES SUBSC	5,639
LICENSES PERMITS, ETC	1,910
YELLOW PAGES ADV	724
RELATED PARTY	227
Less: Public Relations Expense	( )
Non-allowable advertising	(9,676)
Yellow page advertising	(724)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,920

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	101
RELATED PARTY	4,346
Seminar Expense	
EDUCATION & SEMINAR	188
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,635

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $$4,459

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 643 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 54,203
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: PRAIRIE VIEW CARE CENTER-LEWISTOWN #0040303 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,994	
	REPAIRS & MAINTENANCE		39	
				7,033
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		155	
			0	155
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		24,061	
	ELECTRICITY		19,168	
	WATER		3,869	
	CABLE TV - LOBBY		419	
			0	47,517
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,633	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		6,103	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		960	
	FIRE SERVICE		39	
			0	
			0	9,735
7	**OTHER**			
	SCAVENGER		3,954	
	SECURITY SERVICE		0	3,954
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		1,553	
	PURCHASED SERVICES		28	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	14,945	
	PHARMACY CONSULTANT	XVIII B 39-2	1,325	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	13,688	
			0	31,539
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	573	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	573
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	ACTIVITY PROGRAM EXP		709	709
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,206	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,206
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID#: RENAISSANCE CARE CENTER, INC. **#0040295** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	17,800	17,800
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,491	
	ADMINISTRATIVE CONSULTANTS	XIX C	31,341	
	PROFESSIONAL FEES	XIX C	18,026	
			0	53,858
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	9,676	
	EMPLOYEE WANT ADS	XIX F	4,144	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,639	
	LICENSES & PERMITS	XIX F	1,910	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	724	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	22,093
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		341	
	EQUIPMENT REPAIR & MAINTENANCE		1,110	
	OUTSIDE CLERICAL SERVICES		71,040	
	PENALTIES / OVERDRAFT CHARGES	VI 18	254	
	POSTAGE		3,274	
	THEFT & DAMAGE LOSS		79	
	TELEPHONE		8,506	
	MESSENGER SERVICE		0	
				84,604

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	88,443	
	UNEMPLOYMENT COMPENSATION	XIX D	15,242	
	WORKERS COMPENSATION INSURANC	XIX D	28,583	
	HOSPITALIZATION INSURANCE	XIX D	34,962	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	OTHER	XIX D	(28)	167,202
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	188	
	TRAVEL	XIX G	101	
			0	
			0	289
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,130	5,130
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		45,959	45,959
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 506,856